An Analysis and Evaluation of Certificate of Need Regulation in Maryland

Working Paper: Intermediate Care Facilities For Alcoholism and Drug Abuse

Maryland Health Care Commission
Division of Health Resources
4201 Patterson Avenue
Baltimore, Maryland 21215
www.mhcc.state.md.us

September 13, 2001

Donald E. Wilson, M.D., MACP
Chairman

Barbara G. McLean
Interim Executive Director

Table of Contents

Table of Contents

Page

I. INTRODUCTION

A. Purpose of the Working Paper

With the 1999 passage of House Bill 995[1], the General Assembly required the Maryland Health Care Commission to examine the major policy issues of the Certificate of Need process, and to submit an interim report by January 1, 2001[2], followed by a final report by January 1, 2002. The Commission embarked upon a two-year process during which it would develop a series of working papers examining specific issues and implications of changes to the CON model of regulation. Intermediate care facilities for addictions is one of the medical services defined in Commission statute, at Health –General Article §19-123(a), as requiring a Certificate of Need to establish and, in some cases, to expand once established. This report examines the current policy and regulatory issues affecting inpatient psychiatric services, and outlines several alternative options for changes to the Certificate of Need program and their potential implications.

B. Invitation for Public Comment

The Commission invites all interested organizations and individuals to submit comments on the options presented in this working paper. Written comments should be submitted no later than **Friday, October 12, 2001** to:

Barbara McLean, Interim Executive Director
Maryland Health Care Commission
4201 Patterson Avenue, 5th Floor
Baltimore, MD 21215-2299
Fax:410-358-1311
E-mail: bmmclean@mhcc.state.md.us

C. Organization of the Paper

This paper is organized into four major sections. Following this introduction, Part II of the paper contains an overview of intermediate care services in Maryland that provides an inventory of existing providers and data on utilization trends. Part III describes the functions of the state government agencies with regard to intermediate care facility services. Part V of the paper outlines alternative regulatory strategies for the State – continuing, changing, or discontinuing Certificate of Need regulation of these services –that reflect different assumptions about the role and ability of government, and of the health care market, to rationally allocate a crucial service and to protect the public interest.

This paper does not address hospital-based detoxification or other hospital-based addiction programs. These programs can be provided in beds licensed for medical-surgical care.[3]

---

[1] Chapter 702, Acts of 1999

[2] *An Analysis and Evaluation of Certificate of Need Regulation in Maryland: Phase 1 Report to the General Assembly*, available on the Commission's website, www.mhcc.state.md.us

[3] In CY 1999, there were approximately 9,000 inpatient hospital addiction discharges and over 17,000 admissions to emergency room for patients with a primary addiction diagnosis.

II. INTERMEDIATE CARE FACILITIES FOR ADDICTIONS: OVERVIEW

A. Definition of Intermediate Care Facilities (ICFs)

An intermediate care facility for addiction[4] refers to a facility designed to provide sub-acute detoxification and rehabilitation for alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide. Intermediate care facility programs are provided in freestanding facilities or as part of hospital program. An adolescent intermediate care facility is programmatically designed to serve those 12-17 years of age for lengths of stay of 30-60 days. An adult intermediate care facility is programmatically designed to serve those 18 and older for lengths of stay of 7-21 days.

The State Health Plan for Facilities and Services ("State Health Plan") divides the inventory into two tracks of ICF beds, public (Track I) and private beds (Track II). "Private beds" is defined as a privately-owned intermediate care facility beds not sponsored by local jurisdictions and without significant funding by the State or local jurisdictions. These ICFs serve patients providing no less than 30 percent of their annual patient days to the indigent and gray area population in adolescent intermediate care facilities and no less than 15 percent of the facility's annual patients days in adult intermediate care facilities (Track One).

"Publicly-funded beds" are recognized as intermediate care beds in facilities owned and wholly operated by the State or substantially funded by the budget process of the State; or in facilities substantially funded by one or more jurisdictional governments. These facilities are established jointly by providers and the jurisdiction or jurisdictions to meet the special needs of their residents and must reserve at least 50 percent of their proposed annual adolescent or adult bed capacity for indigent and gray area patients (Track Two).

B. Supply and Distribution of Inpatient Facilities in Maryland

Over the past decade several private and public ICFs have closed as a result of managed care policies that have substantially reduced reimbursement. As a result, there are 5 private ICFs and 14 public ICFs that account for 660 beds in the state as of September, 2001.[5] There are three facilities that exclusively serve adolescents ages 12-17. Three regions (Montgomery, Southern Maryland, and the Eastern Shore) pf the State do not have a facility dedicated for children/adolescent addiction care. Table 1 presents an inventory of beds by health planning region, by adult and adolescent, and for public and private ICFs.

[4] There are two types of intermediate care facilities. In addition to ICFs for addiction care, there are intermediate care facilities that serve the mentally retarded (ICF-MR).

[5] In 1990 there were 16 private ICFs that had licensed 900 bed and 14 public programs with 453 ICF beds. There are 693 fewer ICF beds or a reduction of about 48 percent.

Table 1
Inventory of Intermediate Care Facilities by "Public/Private", Adolescents/Adult by Health Planning Region and Jurisdiction, September 2001

Region	Intermediate Care Facility		Number of Beds		Total Beds
	Public	Private	Adult	Adolescent	
Western Maryland	**4**	**1**	**145**	**33**	**178**
Finan Ctr. Massie	V		25	0	25
Finan Ctr. – Jackson	V		0	33	33
Carroll Addict. Rehab. Ctr.	V		20	0	20
Shoemaker Ctr.	V		19	0	19
Mountain Manor		V	111	0	111
Montgomery County	**1**	**1**	**42**	**0**	**42**
Avery Treat. Ctr.	V	0	32	0	32
Mont. Gen. Hosp.		V	10	0	10
Southern Maryland	**2**	**0**	**60**	**0**	**60**
Anchor @ Walden Sierra	V		40	0	40
Reality House	V		20	0	20
Central Maryland	**5**	**2**	**197**	**88**	**305**
Pathways	V		20	20	40
Hope House	V		18	0	18
Turek House	V		63	0	63
Arc House	V		16	0	16
Mountain Manor –East		V	0	68	68
Ashley		V	80	0	80
Eastern Shore	**2**	**1**	**95**	**0**	**95**
Whitsett Rehab. Ctr.	V		20	0	20
Hudson Center	V		33	0	33
Warwick Manor		V	42	0	42
Total	**14**	**5**	**539**	**121**	**660**

Source: Maryland Health Care Commission Files, September 2001

C. Trends in the Utilization of Intermediate Care Facilities

Table 2 shows the distribution of addiction admissions by type of treatment. ICF care constituted 14 percent of all public treatment services according to the Alcohol and Drug Abuse Administration. ICFs have experienced a two percent increase in the number of discharges from FY 1997 to FY 2000. When this data is subdivided by age group, adults experienced a 2.3 percent growth in discharges while adolescents experienced a 9.2 percent decline between FY 1998 and FY 2000.

Table 2
Distribution Of Discharges/Visits By Treatment Type
Maryland Alcohol And Drug Abuse Treatment Programs
Fiscal Years 1997-2000

Program Type	FY 1997		FY 1998		FY 1999		FY 2000		Percentage Difference in Discharges FY 97-00 (neg. #)
	Discharge/ Visits	Percentage of Total	Discharge/ Visits	Percentage of Total	Discharge/ Visits	Percentage Of Total	Discharge/ Visits	Percentage of Total	
Halfway House	779	1.20	751	1.20	775	1.20	720	1.20	(8.5)
ICF	**8,639**	**13.74**	**9,597**	**15.57**	**9538**	**15.70**	**8828**	**14.50**	**2.2**
Outpatient	31,681	44.80	29,622	44.80	27,351	44.80	27,241	44.80	(14.0)
Intensive Op	8,665	13.20	8,653	13.20	9,393	13.20	8,015	13.20	(7.5)
Non-hosp Detox	1,930	3.07	2,063	3.35	1,775	2.92	1,958	3.22	1.5
Correctional	3,434	5.46	3,704	6.01	3614	5.95	5,000	8.21	45.6
Maintenance	4,439	9.90	4,520	9.90	5,732	9.90	5,999	9.90	35.1
Methadone Detox	1,094	1.74	878	1.42	872	1.44	872	1.43	(20.3)
Residential	1,482	1.80	1,166	1.80	995	1.80	1,076	1.80	(27.4)
Hospital Detox	511	0.81	484	0.79	312	0.51	306	0.50	(39.2)
Ambul. Detox	230	0.37	216	0.35	394	0.65	857	1.41	272.6
Total	62,884	100.00	61,654	100.00	60,751	100.00	60,872	100.00	(3.2)

Source: Alcohol and Drug Abuse Administration, DHMH Management Information Services, April, 2000

Table 3
Intermediate Care Facility Utilization
By Discharges, Average Length of Stay and Patient Days
Adults Age 18 +, FY 1998 – FY 2000

	FY 1998	FY 1999	FY 2000	Change FY 98- FY 00
Discharges	7,341	8,255	7,511	2.3
ALOS	18.1	14.8	18.4	1.7
Patient Days	132,831	122,297	138,908	4.6

Source: Alcohol and Drug Abuse Administration, August 2001

Table 4
Intermediate Care Facility Utilization
By Discharges, Average Length of Stay and Patient Days
Children/Adolescents age 0-17, FY 1998 – FY 2000

	FY 1998	FY 1999	FY 2000	Change FY 98- FY 00
Discharges	1,056	890	959	(9.2)
ALOS	42.84	37.4	52.3	22.1
Patient Days	45,238	32,299	50,233	11.0

Source: Alcohol and Drug Abuse Administration, August 2001

FY 2000 data from the Alcohol and Drug Abuse Administration show that sixteen of the nineteen ICF programs are meeting or exceeding their mandated indigent care requirements. One public program and two private programs are not meeting their mandates. Facilities must meet their indigent care mandates in order to docket a CON application. [6]

D. Impact of Managed Care On Addiction Treatment

The rise of managed care has had an enormous impact on all areas of the health care system.[7] This paper lists the impact of this movement and related developments on addiction treatment, and evaluates how they have been associated with a decline in the availability of care for many addicted patients. The problems associated with this decline in the availability of services have affected the extent and quality of employer provided insurance coverage, access to and utilization of treatment services, and Medicare and Medicaid. The Commission is confronted with the following managed care issues:

[6] Indigent care requirements for private ICFs are 15% for adults and 30% for adolescents of total patient days. Indigent care requirements for public ICFs are 50% for adolescents and adult of total patient days.
[7] Maryland has more than 2 million (45%) of 4.5 million insured residents enrolled in HMO's in 1999, compared to the U.S. market share of 35%. *The Inter Study Competitive Edge: HMO Industry Report 2000.*

- Addiction disorders are among the most frequently occurring mental health problems in the United States and impose an enormous cost upon society of $246 billion per year.[8] Despite this, addiction disorders continue to be significantly undertreated.[9]
- A review of the impact of managed care on addiction treatment suggests that some managed care structures and practices may impede the delivery of needed care.[10]
- The Hay Group found that the value of addiction insurance coverage had declined by 75% between 1988 and 1998 for employees of mid- to large-size companies.[11] This figure compares with only an 11.5% decline in the value of general health insurance.
- A trend toward carve-out and for-profit managed behavioral healthcare organizations is associated with lower financial incentives for intensive treatment than those in staff-model and not-for-profit managed care organizations.[12]
- A shift towards managed care has also been associated with a drastic reduction in frequency and duration of inpatient hospitalization, even for many patients who require this level of treatment intensity. It is not clear that this decrease has been offset by a corresponding increase in outpatient treatment utilization.[13]
- Initial positive cost-containment results from managed care models were sometimes attributed to cost shifts to other medical services rather than actual savings.[14]
- Medicare recipients, initially welcomed by managed care, have been increasingly dropped.[15]
- Consequently, costs have shifted dramatically from the private sector to the public sector. The decline in private ICF beds has lead to a greater reliance on public sector ICF beds to provide addiction rehabilitative care.

It is important to note that managing benefit structures is but one of a number of procedures employed to contain costs effectively. In recent years, managed care organizations have broadened the way in which cost-containment may be conceptualized. In particular,

---

[8] U.S. Department of Health and Human Services (1998) *The Economic Costs of Alcohol and Drug Abuse in the United States,* Washington, D.C. G.P.O.

[9] Regier, D.A., et al (1993) *Archives of General Psychiatry,* 50, 85-94 and Newman R. (November 1998) Lawsuits Take Aim at MCO Abuses, *American Psychological Association Monitor, 29, p.25,*

[10] Addiction Treatment Advocates of Maryland, *ATAM Regional Medicaid Meetings Findings and Recommendations, August 2001 (Unpublished)*

[11] The Hay Group (1998) *Substance Abuse Cost Trends 1988-1998. Unpublished report commissioned by the American Society on Addiction Medicine*

[12] Mechanic D. et al. *Management of Mental Health and Substance Abuse Services: State of the Art and Early Results,* The Milbank Quarterly, 73, 19-55, and Institute of Medicine (1996) *Pathways of Addiction: Opportunities in Drug Abuse Research,* Washington, D.C. National Academy Press,

[13] Callahan et al, *Evaluation of the Massachusetts Medicaid Mental Health Substance Abuse Program (1995) Institute for Health Policy, Brandeis University and Asher et al (1995) Evaluation of the Implementation of Pennsylvania's Act 152. Note: Maryland hospital addiction admission have remained at about 10,000 annually between CY 1998-CY 2000 but emergency room admission have declined over the same period by 15% ((18942/16011) See Appendix 1. Preliminary look at outpatient addiction volumes shows a decreasing trend. These outpatient data are still preliminary.*

[14] Larson, M.J. , Paper presented at the Annual Conference of the Research Society on Alcoholism. San Francisco

[15] 53. Freudenheim, M. (October 6, 1998) Exiting medicare is not a sure solution for HMO woes. The New York Times. p A9.

currently managed behavioral healthcare organizations (MBHOs) frequently speak of managing care in addition to managing benefits by which it is meant that care is taken to ensure that only appropriate and necessary care is delivered in the least restrictive settings by qualified professionals. Thus, it is currently more common to see the use of level of care placement criteria, standardized treatment planning methods, and the small but increasing use of evidenced-based treatments. In this way, expensive treatments such as 30-day inpatient alcoholism programs (ICF programs) are utilized more judiciously, at least in theory.

Although the market place in health care has proliferated with different types of managed care, MBHC is most often accessed through one of two types of managed care organizations: 1) staff model HMOs; and 2) managed behavioral health care organizations (MBHCOs).[16] In the staff models, enrollees receive substance abuse or mental health treatment from specialist in-house staff providers. There are certain advantages to the management of behavioral health under this type of arrangement. For example, a patient's overall treatment is consolidated among one provider group leading to better communication and coordination, which can be especially important for patients with multiple medical, psychiatric, and substance abuse problems. In addition, there are financial incentives since reductions in mental illness and substance abuse are reported to offset medical costs.

In contrast, MBHCOs, which are also referred to as "carve out vendors", are managed care organizations hired by employers to organize specialized mental health and substance abuse treatment for enrollees independently from overall health care. MBHCOs contract with mental health and substance abuse specialist groups or preferred provider networks. Typically, MBHCOs employ specialist "gatekeepers" to assess and monitor patient need for access to and utilization of treatment within the network. Carve out arrangements now administer the vast majority of behavioral health care for people with private health insurance.[17] Increasingly, staff model HMOs and traditional fee-for-service insurers are employing carve-out vendors to provide managed behavioral health care.

The carve-out format is attractive to the insurer in that it entails the potential advantage of offering more highly specialized treatment and personnel than in the staff model HMO. These may be more successful in effecting a cost conscious approach to providing care. A potential disadvantage, however, is that MBHCOs, which do not stand to benefit from the medical cost-offset, lack an inherent financial incentive to provide more costly treatment of behavioral disorders if it is more effective.[18] This can lead to promoting less costly short-term approaches over ones that could effect a more beneficial long-term outcome.

E. Reimbursement Issues Impact on Treatment

The literature on managed care thus far suggests that 1) the majority of insured Americans have mental health and substance abuse covered by managed behavioral care organizations; 2) the value of benefit structures of such coverage are on the whole more restrictive than previous insurance arrangements; and 3) while overall cost has been held in line

[16] Institute of Medicine (1996) *Pathways of Addiction: Opportunities in Drug Abuse Research, Washington, D.C. National Academy Press*

[17] Schoenbaum, et al; (1998) *Costs and utilization of Substance Abuse Care in Privately Insured Population Under Managed Care*, Psychiatric Services , 49, 1573-1578

[18] Mechanic et al (1995) *Management of Mental Health and Substance Abuse Services: State of the Art and Early Results*, The Milbank Quarterly, 73, 19-55

with general medical health care, the value of coverage for substance abuse has tended to decline on average.

There is a consensus among clinicians and researchers that substance abuse is undertreated; and there are several major studies of substance abuse treatment under managed care that shed light on access, utilization, and treatment intensity. The Institute of Medicine summarized several major studies on the effect of managed care on substance abuse treatment.[19] Although naturalistic and lacking controls, all of these studies have the value of comparing managed care with unmanaged care or different types of managed care.

These studies support the view that inpatient substance abuse treatment has been curtailed under managed care. While outpatient substance abuse treatment is effective for many uncomplicated substance abuse case, many other more severely compromised patients (e.g., dual diagnosis patients) may need inpatient services. The above data suggest this may be harder to achieve under managed care. In addition, the lowered inpatient utilization rates above do not appear to show corresponding increases in outpatient utilization of services which support the notion that managed care practice may lead to under treatment of substance abuse.

F. Drug Treatment Task Force Final Report

Recommendations proposed from the Drug Treatment Task Force Chaired by Lieutenant Governor Kathleen Kennedy Townsend and Vice-Chair Delegate Dan Morhaim, M.D. would increase addiction treatment funding by $300 million over the next ten years. This has had am impact upon the availability of ICF services. In FY 2001, there was a $25 million and in FY 2002 a $22.2 million increase in public treatment funding.[20] In anticipation of this increased funding, the Commission amended the State Health Plan so that public ICFs could be approved if there were commensurate public spending. This Task Force's needs assessment identified 20 of the 24 Maryland jurisdictions as required additional intermediate care facilities (ICFs) or detoxification service capacity.[21]

A second factor influencing the demand, and ultimately, the supply of ICF beds, is the Medicaid Substance Abuse Improvement Initiative developed by the Medicaid Drug Treatment Workgroup, an outgrowth of the Drug Treatment Task Force. The reforms being made to the Health Choice program seek to proactively identify enrollees needing substance abuse treatment allowing self-referral to a provider even if the provider is not part of the Managed Care Organization/Behavioral Health Organization Network. Changes constructed to remove barriers to care including prompt payment of providers within 30 days and expansion of networks. As a fallback position, the Medicaid Drug Treatment Workgroup is simultaneously designing an addiction carveout that would replace the Initiative if it fails to produce the needed reforms and increased access to the addicted population. Evaluation of the Medicaid Substance Abuse Initiative would be finalized in April 2002 with a decision of whether to carveout addiction services is scheduled to be decided in May 2002. If the decision is made to move forward with the addiction carveout these reforms are forecasted to be in place by January 2004.

---

[19] Institute of Medicine (1996) *Pathways of Addiction: Opportunities in Drug Abuse Research, Washington, D.C.: National Academy Press*

[20] *Drug Treatment Task Force Final Report, Blueprint for Changed: Expanding Access to and Increasing the Effectiveness of Maryland's Drug and Alcohol Treatment System, February 2001*

[21] Drug Treatment Task Force: *Filling In the Gaps: Statewide Needs Assessment of County Alcohol and Drug Treatment Systems, February 29, 2000*

Specific reforms in the private insurance market have not been specifically articulated. However, the Drug Treatment Task Force Report encourages pursuing meaningful implementation of parity for drug and alcohol treatment services covered by private health insurance. The report recommends that stakeholders work together to make the necessary changes that would improve the ability of insured citizens to use their private health coverage when seeking drug and alcohol treatment.

III. GOVERNMENT OVERSIGHT OF INTERMEDIATE CARE FACILITIES IN MARYLAND

Government oversight of intermediate care facility services in Maryland, including staff and program operation, is principally the responsibility of agencies within the Department of Health and Mental Hygiene, including the Alcohol and Drug Abuse Administration; Medical Assistance Program – HealthChoice, and the Office of Health Care Quality. Although this report focuses on the oversight responsibilities of the Commission, it is important to understand how intermediate care facility services are regulated by other agencies of state government, particularly when considering a potential alternative to the current framework of Certificate of Need review.

A. Department of Health and Mental Hygiene

- **Alcohol and Drug Abuse Administration**

The Maryland Alcohol and Drug Abuse Administration maintains a statewide integrated service delivery system by:

- gathering and analyzing data on the nature and extent of substance abuse;
- planning and funding prevention and treatment services;
- monitoring programs and providing technical assistance and training to service providers;
- assessing services and evaluating client outcomes;
- collaborating with federal, state, and local agencies to efficiently utilize existing prevention and treatment resources and to increase services based upon need; and
- responding to court orders for the evaluation and treatment of addicted offenders.

- **Medical Assistance Program – HealthChoice**

HealthChoice is the name of the Maryland's statewide mandatory managed care program which began in 1997. The HealthChoice Program provides health care to most Medicaid recipients. Eligible Medicaid recipients enroll in a Managed Care Organization (MCO) of their choice and select a Primary Care Provider (PCP) to oversee their medical care. The MCO enrollee selects a PCP who is part of their selected MCO's provider panel either at the time of enrollment with the enrollment broker or once enrolled in their MCO.

MCOs must meet specific standards set forth in the regulations for treating seven special needs populations. These include 1) children with special health care needs; 2) individuals with a physical disability; 3) individuals with a developmental disability; 4) pregnant and postpartum women; 5) individuals who are homeless; 6) individuals with HIV/AIDS; and 7) individuals with a need for substance abuse treatment.

Substance abuse treatment is a mandatory covered benefit under the MCO. The benefits include: 1) screening for substance abuse, using an instrument comparable to the Michigan Addiction Screening Test (MAST) or (Cut down, Annoyed, Guilty, and Eye opener) C.A.G.E., as part of the enrollees initial health screen, initial prenatal screen, or when behavior or physical status indicates the likelihood of substance abuse; 2) a comprehensive assessment following a positive screen; and, 3) a continuum of substance abuse services. Substance abuse treatment

services include: a comprehensive substance abuse assessment; outpatient substance abuse treatment; detoxification treatment either outpatient or inpatient if medically necessary and appropriate; residential addiction programs for children under 21, and for Temporary Cash Assistance Program (TCA) adult parents (21+); and, addiction rehabilitative services in halfway houses and therapeutic communities for adult parents eligible in (TCA). For persons with HIV/AIDS and pregnant substance abusing women, MCOs must provide access to substance abuse services within 24 hours of request.

There are new policy changes for substance abuse treatment services for HealthChoice enrollees. The new Substance Abuse Improvement Initiative, effective Jan 1, 2001, enhances access to treatment services through a self-referral process, ensures prompt payment of clean claims, and encourages MCOs and their Behavioral Health Organizations (BHOs) to contract with treatment providers.

- **Office of Health Care Quality**

The Office of Health Care Quality (OHCQ) is mandated by State and federal law to determine compliance with the quality of care and life safety standards for a wide variety of health care facilities and related programs, including intermediate care facilities for addiction. The Developmental Disabilities, Substance Abuse, and Community Residential Programs unit ensures that all assisted living programs, all residential and outpatient mental health programs, all alcohol and drug abuse treatment programs and services and all facilities for the developmentally disabled meet the requirements of State regulations.

OHCQ no longer licenses programs but all programs including intermediate programs must be certified by OHCQ. ICFs are certified by OHCQ every two years regardless of whether or not the ICF has attained accreditation from the Joint Commission of Healthcare Organizations. The OHCQ reviews the plans for service, minimum physical facility requirements, staffing, intake procedures, individualized treatment plans, family care services, dietary services, emergency contingencies, and cooperation with outside service providers.

B. Department of Public Safety and Department of Juvenile Justice

The criminal and juvenile justice programs spend a significant amount of funding on drug and alcohol programs serving the criminal justice population. In FY 2001, the total amount of funding spent on drug treatment was almost $31 million.[22] Treatment programs serving this population operate inside institutions or incarceration and within communities. These programs are not reviewed by CON but provide a substantial part of the treatment capacity. In FY 2001, several counties and Baltimore City allocated increased spending for the expansion of treatment programs serving individuals involved in the criminal justice system.

C. Maryland Insurance Administration (MIA)

The Maryland Insurance Administration (MIA) regulates the practice and the financial performance of both health insurers, third party administrators, and "private review agents" who perform utilization review as well as prior authorization of addiction services for insurers. It establishes requirements both for rate-making and disclosure and for fair trade practices.

[22] This funding appears in several State agency and local government budgets.

A patient may appeal a grievance decision to the MIA for an external review of the carrier's decision (See D- Office of the Attorney General below). In most cases, patients must exhaust the carrier's internal grievance process prior to filing a complaint with MIA, with few exceptions. The MIA handles consumer complaints regarding medical necessity, quality of care, and contract issues decisions made by HMOs and other health insurers.[23]

The Maryland Insurance Administration assumed responsibility for qualifying and regulating the "private review agents" empowered to act as third-party utilization entities in managing behavioral health care in the state. This authority had been originally given to the Office of Health Care Quality , and was transformed from the licensing statute (at §19-301, *et seq*, of the Health –General Article) to become Subtitle 10B, Title 15 of the Insurance Article, Annotated Code of Maryland .[24]

D. Office of the Attorney General, Health Education and Advocacy Unit (HEAU)

The 1998 General Assembly passed the Appeals and Grievance Law to provide patients with an enhanced ability to resolve disputes with their health insurance carriers regarding denial of coverage by carriers.[25]

The process outlined in the Appeals and Grievance Law begins with an adverse decision issued to the patient by the carrier. An adverse decision is a written decision by a health insurance carrier that a proposed or delivered health care services are not medically necessary, appropriate, or efficient. After receiving an adverse decision, a patient may file a grievance through the carrier's internal grievance process. The Health Education and Advocacy Unit of the Office of the Attorney General is available to attempt to mediate the dispute, or if necessary, to help patients file grievances with carriers.

It was reported within the November 2000 annual HEAU reported that only 16 percent of grievances related to substance abuse were overturned as compared with 58 percent were overturned for decision s related to other types of care. The report points to the vague, subjective, and less measurable utilization criteria used in the addiction field as the reason for this disparity. The report calls for standardized clearly written utilization review criteria.[26]

E. Maryland Health Care Commission

Through the health planning statute, the Maryland Health Care Commission ("MHCC") is responsible for the administration of the State Health Plan, which guides decision making under the Certificate of Need program, under which actions by certain health care facilities and

[23] In FY 2000, *The Maryland Insurance Administration's 2000 Report on the Health Care Appeals and Grievance Law*, February 2001 reported that 12% (390) of the complaints received were for behavioral health grievances, including mental health and addiction diagnoses).
[24] This transfer was effected by Chapters 11 and 112, Acts of 1998.
[25] Maryland Code Annotated, Insurance §15-10A-01 through §15-10A-09
[26] Office of the Attorney General, *Annual Report on the Health Insurance Carrier Appeals and Grievances Process, Health Education and Advocacy Unit*, Consumer Protection Division, November 2000

services are subject to Commission review and approval.[27] Through the Certificate of Need program, the Commission regulates market entry and exit by the health care facilities and individual medical services covered by CON review requirements, as well as other actions the regulated providers may propose, such as increases in bed or service capacity, capital expenditures, or expansion into new areas.

"Certificate of Need" as a regulatory tool has three levels, each initiated by a written notice or letter of intent to the Commission. For confirmation that a Certificate of Need is not required to establish a certain kind of health care facility or service, a person requests a "determination of coverage" by CON requirements. Staff and counsel analyze the proposal according to the Commission's statute and applicable regulations, and if CON review and approval is not needed to undertake the project, the Executive Director issues a determination to that effect as the Commission's designee.

Proposed new health care facilities and specified actions by existing facilities that do require CON approval come to the Commission either in response to a schedule regularly published in the *Maryland Register*, or, if no schedule has been published for a particular service, as an unscheduled review. Procedural rules dictate how unscheduled reviews must be administratively handled so as to permit a comparative review for the new service, if that is appropriate and practical. The CON review process itself, proceeds according to additional rules set forth in COMAR 10.24.01, evaluates an application against all applicable standards and need projections for the service in the State Health Plan, and applies general review criteria related to the need for and the likely impact of the proposed project on the health care system. Statute requires that staff (or a Commissioner appointed as a reviewer in a comparative review) bring recommendations on a proposed project to the full Commission within 90 days of docketing.[28] The first thirty days after docketing are set aside as a public comment period, in which interested members of the public, as well as "interested parties" in the legal sense, may comment on the proposal or, if they meet criteria in regulation, enter to review in opposition to the project.

Since 1985, health planning statute has permitted the Commission to find, "in its sole discretion," that certain actions by existing health care facilities –if the facilities proposing them are merging or are proposing to further consolidate or to reconfigure their bed capacity or services – may be exempted from the Certificate of Need requirement that would otherwise apply. This so-called "exemption" from the CON requirement may be granted through action by the Commission for several kinds of actions proposed "pursuant to a consolidation or merger" of two or more health care facilities, if the proposed action:

[27] The MHCC also establishes a comprehensive standard health benefit plan for small employers, and evaluates proposed mandated benefits for inclusion in the standard health benefit plan. In its annual evaluation of the small group market, the Commission considers the impact of any proposed new benefit on the mandated affordability cap of the small group market's benefit package, which is 12 percent of Maryland's average wage, and the impact of any premium increases on the small employers. With regard to nursing –home level care, Maryland's Comprehensive Standard Health Benefit Plan for Small Businesses currently includes a "skilled nursing facility care" benefit characterized as "100 days as an alternative to otherwise covered care in a hospital or other related institution, i.e. nursing home," which carries " a $20.00 co-payment or applicable coinsurance, whichever is greater."

[28] Docketing is the forma start of a CON review; the time period in which a recommendation is to come to the full Commission is 150 days, if an evidentiary hearing is held. However, 1995 legislation to streamline the CON review process mandated the adoption of regulations that restrict evidentiary hearing to those cases in which the "magnitude of the impact" of a potential new facility or service merit the additional time and transaction cost.

- Is "not inconsistent with" the State Health Plan[29];
- "Will result in the delivery of more efficient and effective health care services"; and
- Is "in the public interest."[30]

Market Entry/Exit

Entry into the market for a proposed new intermediate care facilities or bed capacity has been explicitly regulated through Certificate of Need since the 1988 enactment of a list of "medical services" subject to CON if established by an otherwise-regulated health care facility. (Haven't ICFs been regulated since the Federal Health Planning Legislation and enactment of the MHRPC?) As with all Certificate of Need review in Maryland, the analysis [31]of applications for CON approval for new facilities or expanded bed capacity evaluates how proposed projects meet the applicable standards and policies in the State Health Plan, and how they address the six general review criteria found in the Certificate of Need procedural regulations in COMAR 10.24.01.07.[32] The State Health Plan currently in effect (COMAR 10.24.14) requires that a facility obtain a separate Certificate of Need for adolescent and/or adult intermediate care facilities.

The State Health Plan rules and standards that are applied to CON reviews of proposed new facilities or expansions fall into several distinct categories, including:

- **docketing standards**, which determine whether applications for new facilities or expansions will be accepted and may be docketed for review;
- **review standards**, which are applied to all applications, and provide a composite description of what the Commission has established – through its staff research, deliberation, and the public adoption process – should characterize a facility or kind of service under review.; and
- **preference rules**, which give guidance and an opportunity for applicants in comparative reviews to compete with other applicants for a CON by addressing additional rules that are in the public interest;
- **approval rules**, which set threshold standards that must be met, or a proposed project may not be recommended for Commission approval; and
- **modification rules** which guide the review of certain kinds of changes proposed to projects already granted Certificate of Need approval

[29] "Or the institution-specific plan developed and adopted by the Commission," pursuant to its authority at Health-General Article §19-122, Annotated Code of Maryland

[30] Health-General §19-123(j)(2)(iv)

[31] Bed increases may be authorized by the Commission without CON review through the statutory "waiver bed" rule that permits increases of 10 beds or 10 percent of total beds, whichever is less, two years after the last change in licensed capacity. An ICF may add may add ten beds or 40 percent of the current bed capacity, whichever is less.

[32] In brief, these criteria require an application to: (1) address the State Health Plan standards applicable to the proposed project (COMAR 10.24.14 Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services); (2) demonstrate need for the proposed new facility or service; (3) demonstrate that the project represents the most cost-effective alternative for meeting the identified need; (4) demonstrate the viability of the project by documenting both financial and non-financial resources sufficient to initiate and sustain the service; (5) demonstrate the applicant's compliance with the terms and conditions of any previous CONs; and (6) "provide information and analysis" on the impact of the proposed project on existing health care providers in the services area."

The method of projecting future need for intermediate care facilities in the Plan currently in effect is regional in its focus, based on the five historic health planning areas: Western Maryland (which since 1987 has included Carroll County, by the designation of the County's government), Montgomery County, Central Maryland (Baltimore City and the Baltimore, Harford, Howar5d, Anne Arundel), Southern Maryland (including Prince George's and the Tri-County Region), and the Eastern Shore.

State statutes and regulation require that an intermediate care facility (ICF) receive a Certificate of Need to close a facility.[33] However, none of the ICFs that have closed have submitted a Certificate of Need application when declining financial situation or bankruptcy has involuntarily forced closure.

[33] Health General §19-123(j)(2)(iii)1, COMAR 10.24.01.02A(4)(f)(g)

IV. MARYLAND REGULATION OF INTERMEDIATE CARE FACILITIES FOR ADDICTIONS COMPARED TO OTHER STATES

Figure 1 illustrates Maryland is one of 36 states, plus the District of Columbia, that maintains a Certificate of Need program for some number of new or expanded health care facilities and services. Maryland ranks in the lower third of what the American Health Planning Association ("AHPA"), on whose annual survey of all CON programs the following figure is based, calls its "Relative Scope and Reviewability" listing, which lists the state CON programs in descending order, based upon such factors as the number of services regulated, and the dollar level of capital and service review thresholds.

Commission Staff accessed the AHPA's internet forum of state CON and other major health regulatory programs to determine which of the 37 programs include intermediate facilities for addiction or residential addiction facilities including bed capacity in the scope of their respective Certificate of Need review. AHPA's listing shows that 24 of the 36 programs regulate intermediate care facilities or residential alcohol and drug abuse programs through CON review. Staff submitted e-mail requests for information and received the following replies.

Since its inception in 1974, Illinois' CON program has only had jurisdiction over licensed health care facilities. Thus, residential substance abuse facilities would need to come before the Planning Board. Additionally, Illinois' CON program was revised in April 1999. As part of that revision the Substance Abuse / Addiction Treatment category of service was deregulated. At that point, the Planning Board no longer reviewed facilities' proposals for the development and/or expansion of these services. When this revision occurred, hospitals that had substance abuse/addiction treatment beds had those beds converted to medical / surgical beds.[34]

The State of Florida has Certificate of Need regulations for hospital-based inpatient substance abuse services for children, adolescents and adults in need of these services regardless of their ability to pay. This rule regulates the establishment of new hospital inpatient substance abuse services, the construction or addition of new hospital inpatient substance abuse beds, the conversion of licensed hospital beds to hospital inpatient substance abuse beds, and specifies which services can be provided by licensed or approved providers of hospital inpatient substance abuse services.[35]

The State of Montana requires a Certificate of Need and licensing of free-standing chemical dependency units. Hospital-based units may be under the license of the hospital and may not need a Certificate of Need.[36]

In South Carolina, "free-standing medical detoxification facilities, inpatient treatment facilities (ICFs), and narcotic treatment program (methadone maintenance)" require a Certificate of Need. Inpatient treatment centers should be available within 60 minutes one-way travel for 90% of the service area's population. Inpatient Treatment Facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for each in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an

[34] Don Jones, Illinois Department of Public Health , August 15, 2001, E-Mail
[35] Jeffery Greg, Florida Department of Health Care, August 22, 2001, E-Mail
[36] Walt Timmerman, Montana Department of Public Health and Human Services, Phone Call August 16, 2001

inpatient facility providing detoxification services to their clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.[37]

South Carolina's inpatient treatment centers "Residential Treatment Program facilities (halfway house) do not require a Certificate-of-Need, however, an exemption request is required prior to the establishment of such a program. Outpatient and social detoxification addiction facilities do not require Certificate of Need.

A Certificate of Need would not be required in Alaska and Missouri for a free-standing residential substance abuse facility. If the facility is a part of a hospital, the only requirement is if it costs $1 million or more, then it would have to go through the CON process.[38]

In the State of Virginia, a Certificate of Need is required for "inpatient substance abuse treatment services" are substance abuse treatment services provided through distinct inpatient units of medical care facilities or through free-standing inpatient substance abuse treatment facilities. Inpatient substance abuse treatment beds are licensed by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). A bed need methodology and standards are used to determine need by planning districts and regulate availability and other qualitative standards.[39] The State of West Virginia also has a methodology and standards to project freestanding ICF bed for adolescents and adults.[40]

In the State of Oklahoma chemical dependency units in general acute hospitals, and freestanding alcoholism treatment facilities must be approved under Oklahoma's Certificate of Need laws before: establishing a new facility; increasing psychiatric or chemical dependency treatment beds at an existing facility; converting existing beds to serve persons under age 18; transferring ownership or operation of a facility; or spending $500,000 or more on any project.[41]

The States of Washington, New Jersey, Michigan, Arkansas, and Oregon do not review residential substance abuse facilities under CON. There are, however, licensure requirements.[42]

---

[37] South Carolina Plan, Alcohol and Drug Abuse Facilities (2001) South Carolina State Health Planning Committee, South Carolina Department of Health and Environmental Contraol

[38]Thomas Piper, Missouri Certificate of Need Program, August 22, 2001 E-Mail and David Pierce, Alaska Department of Health and Social Services, August 20, 2001,E-Mail

[39] E. Bodin, Virginia Department of Health, August 20, 2001, E-Mail

[40] Daryle Stepp, West Virginia Health Care Authority, August 22, 2001, E-Mail

[41] Darlene Sardis, Oklahoma Health Resource Development Service, August 20, 2001, E-Mail

[42] Janis Stigman, Washington Department of Health; John Calabria, New Jersey Department of Health; Catherine Stevens, Michigan Department of Community Health, Jana Fussell, Oregon Health Division, August 14, 2001 E-Mails

FIGURE 1

COMPARISON OF NUMBER AND SCOPE OF HEALTH CARE FACILITIES & SERVICES COVERED IN STATES WITH CON PROGRAMS

RANK[43]	*STATE*[44]	*Substance Abuse*	*Acute Care*	*Air Ambulance*	*Amb Surg Ctrs*	*Burn Care*	Business Cmptrs	*Cardiac Cath.*	*CT Scanners*	*Gamma Knives*	*Home Health*	*ICF/MR*	*Lithotripsy*	*Long Term Care*	*Med Off Bldg*	*Mobile HiTech*	*MRI Scans*	*Neo-ntl Int Care*	*Obstetric Svcs*	*Open Heart Svcs*	*Organ Transplant*	*PET Scans*	*Psychiatric Svcs*	*Rad Therapy*	*Rehab*	*Renal Dialysis*	*Res Care Fac*	*Subacute*	*Swing Beds*	*Ultrasound*	*Capital Threshold*	*Other Services*[45]
31.2	ME	**X**	X	X	X	X		X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X			X	X	X	
30.0	GA	**X**	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X		X	X
28.6	CT	**X**	X	X	X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X		X		X	X	X	X
27.0	AK	**X**	X	X	X	X		X	X	X	X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
25.2	WV	**X**	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X
22.5	VT	**X**	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X			X		X	
21.0	MO	**X**	X		X			X		X		X	X	X		X	X	X	X	X		X	X	X	X	X	X	X			X	X
20.9	SC	**X**	X		X			X		X	X	X	X	X		X	X	X	X	X		X	X	X	X			X			X	
19.2	NC	**X**	X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X			X		X	X
18.0	MS	**X**	X		X			X		X	X	X	X	X			X			X		X	X	X	X	X	X		X		X	
16.1	DC	**X**	X		X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		X	
16.0	TN	**X**	X	X	X			X	X		X	X	X	X			X	X		X		X	X	X	X			X	X		X	X
16.0	AL	**X**	X		X			X		X	X		X	X			X	X	X	X	X	X	X	X	X	X			X		X	X
15.3	**MD**	**X**	**X**		**X**	**X**		**X**			**X**	**X**		**X**				**X**	**X**	**X**	**X**		**X**		**X**			**X**	**X**		**X**	**X**
15.2	RI	**X**	X		X			X	X	X				X		X	X	X	X	X	X	X	X	X	X			X	X		X	
15.0	HI	**X**	X	X	X	X		X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	
14.4	MI		X	X	X			X	X	X			X	X		X	X	X		X	X	X	X	X				X		X	X
14.4	KY		X		X			X			X	X	X	X		X	X	X		X	X		X	X	X		X	X			X	X
13.3	IL		X		X	X		X		X		X		X	X			X	X	X	X	X	X	X	X	X		X	X		X	X
13.2	NJ		X			X		X			X	X		X				X		X	X		X		X		X				X	
13.2	NY	**X**	X		X	X		X	X	X	X	X	X	X		X	X	X		X	X		X	X	X	X			X	X	X	
12.6	WA		X		X	X					X			X				X	X	X	X				X	X		X	X		X	X
11.7	NH	**X**	X		X			X	X				X	X		X	X			X			X	X	X						X	
8.4	AR										X	X		X													X	X	X		X	X
8.1	IA				X			X				X		X						X	X	X		X							X	X
8.0	VA	**X**	X		X			X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X						X	X
7.7	FL	**X**	X			X						X		X				X		X	X		X					X				X
7.0	OK	**X**										X		X									X								X	X
6.3	MT	**X**			X						X	X		X											X				X		X	
4.8	MA	**X**		X	X					X			X	X			X	X		X	X	X	X	X	X		X				X	X
4.8	DE		X		X			X					X	X								X		X							X	X
4.4	WI											X		X														X			X	X
3.5	NV	**X**	X		X							X		X											X			X			X	
3.0	NE													X											X						**	
2.4	OR													X															X		**	
1.0	OH													X																	X	X
0.4	LA											X		X																		

This chart is adapted from the American Health Planning Association's annual graphic, last updated in AHPA's 2001 Directory of Health Planning Policy & Regulatory Agencies (12th ed.), which compares the "National Relative Scope and Reviewability Threshold of CON Regulated Services" among the states. The 2001 version of AHPA's graphic contained some errors with regard to Maryland's services, which have been corrected in Staff's adaptation. Consequently, the "severity" index as calculated according to several factors, including number of services regulated and level of capital review threshold, may not precisely reflect Maryland's "weight" or "severity" according to AHPA's formula, compared to other CON states. However, the chart's relative position of Maryland's CON program--which does not cover a significant number of health care facilities and services regulated by many other states--would still be in the middle range of CON programs, nationwide.

** Any capital expenditure for LTC

[43] No. of services x weight as determined by the Missouri CON Program.
[44] Including the District of Columbia.
[45] Services in addition to those most often CON-regulated.

V. ALTERNATIVE REGULATORY STRATEGIES: AN EXAMINATION OF CERTIFICATE OF NEED POLICY OPTIONS

The options discussed in this section represent alternative regulatory strategies to achieve the policies, goals and objectives embodied in Maryland's Certificate of Need program. The role of government in these options describes a continuum varying from the current role (Option 1), to a more expanded role on one end of the continuum (Option 2), to essentially no role, at the other end of the range of options (Option 6). The options below, singly or in combination, suggest potential alternative strategies that could be considered in the context of the larger issue of the regulation of health care services in Maryland. This is not an exhaustive list of options. The Commission expects other opinions and ideas to be generated through the public comment process. The questions suggested in the guiding principles in the Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland*: *Study Overview*, provide a framework for the evaluation of these options.

Option 1 - Maintain Existing Certificate of Need Program Regulation

This option would maintain the Certificate of Need program as it currently applies to intermediate care facilities for addictions. Under current law, establishing a new ICF – or new division of service designation between adolescent and adult –requires a Certificate of Need, based on Commission review of an applicant's consistency with the State Health Plan policies, standards, need projections, and other review criteria. The Track I (private ICFs) and Track II (public ICFs) would be maintained.

Option 2 - Expand Certificate of Need Program Regulation

As levels of the medical system are interrelated as patient step –up and down - the treatment continuum, so to must the substance abuser have available appropriate services to meet their needs. This option would increase the types of facilities covered under "related institutions" to include non-hospital detoxification, halfway houses, therapeutic communities, and long term care addiction facilities.

These are inpatient facilities that provide many of the services provided in an intermediate care facility for addiction care. Non –hospital detoxification services are provided on a regular basis in ICFs. Halfway houses are the next less intensive residential based option for substance abusers as they attempt to become mainstreamed into the community. Therapeutic communities and long term care addiction facilities provide ongoing treatment and support services for longer periods of recuperation.

Option 3 - Partial Deregulation of Intermediate Care Facilities from Certificate of Need Review- Alcohol and Drug Abuse Administration

This option would deregulate the public ICFs from CON review and leave oversight of public beds to the Alcohol and Drug Abuse Administration. Under this option regulation of private ICF providers would be maintained.

Since there is a significant shift in the public sectors for the responsibility to care for the substance abusing individual, this option would give the responsibility of planning for public ICFs to the Administration where most of the funding is aggregated.

Option 4A - Total Deregulation of Intermediate Care Facilities from Certificate of Need Review - Alcohol and Drug Abuse Administration

Option 4B - Total Deregulation of Intermediate Care Facilities from Certificate of Need Review - Proposed Drug and Alcohol Council

The first sub-option (4A) would give total planning responsibility for ICFs to the Alcohol and Drug Abuse Administration. The ADAA is the State agency responsible for the planning, development, coordination and delivery of services to prevent harmful involvement with alcohol and other drugs and to treat the illness of chemical addiction. The ADAA has increased grant funding to ICFs by 16 percent between FY 1999 to FY 2001 from $11,564,603 to $13, 423,865. The Commission expects the majority of ICF expansion to increase in the public sector (Track II). Letters of intent for CON applications for new ICF capacity come from public applicants in Baltimore City and Baltimore and Wicomico Counties.

The second sub-option (4B) would give this authority to the proposed Drug and Alcohol Council that was proposed by the Drug Treatment Task Force.[46] Maryland's Alcohol and drug abuse system is becoming more sophisticated and complex as it seeks to serve clients involved in a variety of public and private systems, including health welfare, child welfare, criminal justice systems and insurance and reimbursement systems. Since increasing number of agencies are involved in funding and overseeing the delivery of treatment services, an elevated level of statewide coordination would improve the alcohol and drug treatment's ability to deliver effective services. The Drug and Alcohol Council would facilitate the necessary statewide coordination and participation.

Option 5A - Deregulate Intermediate Care Facility Services from Certificate of Need Review; Create Data Reporting Model to Encourage Quality of Care

Another option for intermediate care facility service regulation involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting, to encourage continuous quality improvement through the gathering and periodic publication of comparative information about existing programs. Option 5 supports the

[46] Drug Treatment Task Force Report, *Blueprint for Change: Expanding Access to and Increasing the Effectiveness of Maryland's Drug and Alcohol Treatment System*, February 2001

role of government to provide information in order to promote quality health services. Performance reports, or "report cards" as they have been come to be called, are intended to incorporate information about quality decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers. Performance reports can also serve as benchmarks against which providers can measure themselves, and seek to improve the quality in any areas found deficient. As such, report cards may both inform consumer choice and improve the performance of health services. Report cards for intermediate care facilities services – as for any other health care service – could be implemented in at least two ways: public report cards designed for consumers, or performance reports designed to provide outcomes information and best-practice models for providers

Option 5B - Public Report Card for Consumers Specific for Intermediate Care Facility Services

This option would create a vehicle for public reporting of basic service-specific information in a report card style format, promoting consumer education and choice. Behavioral health service report cards could be designed to report on facilities, physicians or provider groups, or a combination. In response to a 1999 legislative mandate, the Commission is proceeding with the development and implementation of hospital and ambulatory surgery facility report cards similar to the HMO report cards it currently produces. Therefore, this option for intermediate care facility services could perhaps be the subject of a future supplementary report, and could eventually be extended to other substance abuse treatment facilities.

Option 5C - Provider Feedback Performance Reports

Under this option, the Commission, ADAA, or another public or contracted private agency would establish a data collection and feedback system designed for use by providers. Like the report card option, this involves mandatory collection of detailed outcomes and process information from all intermediate care facilities to measure and monitor the quality of care using a selected set of quality measures specific to intermediate care facility programs. This option is consistent with the recent national policy debate regarding the need for more information and improved accountability for outcomes. While CON typically serves as a means to create and allocate new facility-based medical service capacity on a rational, planned basis and is not generally intended to monitor quality after an approved program begins operation, this option does further that objective.

Option 6 - Deregulation of Intermediate Care Facility from Certificate of Need Review

Certificate of Need as a regulatory tool to control cost or address quality of care has been questioned by advocates for a totally market-driven, entrepreneurial approach to establishing and providing health care services. In Maryland, it can be argued that quality of care, once a CON-approved facility or service begins operating, is addressed by the standards of JCAHO and the Office of Health Care Quality. It could also be argued that since a large percentage of funding

for treatment has been transferred from the private sector to the public sector that those who budget the funding of these services should be responsible for the planning of these services.

Under this sixth option, all CON review requirements related to both market entry and exit would be eliminated for intermediate care facility services in Maryland

Repeal of CON has been associated with increases in supply in several states. The complex reimbursement issues and length of stay constraints affecting this particular medical services –discussed in some detail in this Working Paper – may well mean that this increased supply would be less likely in intermediate care facilities. A bigger concern at the present time may be the number of ICFs considering discontinuing their service, rather than those who would increase their capacity if CON review were not required.

If the factors leading some facilities to reconsider their existing intermediate care facilities were to be addressed, the effect of duplicating programs that require professional staff already in short supply, and that need to be available 24 hours per day, would add direct staffing costs and indirect overhead to the system. The question raised by this option, proposed in all of the Working Papers to date and to be included in the remainder still to come, is whether the cost efficiencies to be achieved through competition (if any competition now exists with ICFs) would offset the cost pressures generated by competition, in the long run.

VI. SUMMARY

Intermediate care facility services are among the medical services defined in health planning statute that requires a CON to establish and expand an ICF. This report examines the current policy and regulatory issues affecting inpatient substance abuse rehabilitation and non-hospital detoxification services, and outlines several alternative policy options for changes to CON regulation, and the potential implications of those changes. Figure 2 summarizes the policy options discussed in this paper. It is the expectation of the Commission that the public comment process involved in evaluating the CON program will identify additional policy options and approaches that merit consideration.

Figure 2
Summary of Regulatory Options

Options	Level of Government Oversight	Description	Administrative Tool
Option 1 Maintain Existing CON Regulation	No Change in Government Oversight	- Market Entry Regulated by CON - Market Exit Regulated through CON	Commission Decision (Certificate of Need/Notice)
Option 2 Expanded CON Regulation	Increased Government Oversight	- Market Entry Regulated by CON - Market Exit Through CON	Commission Decision (Certificate of Need/Notice)
Option 3 Partial Deregulation of Intermediate Care Facilities	Change and Transfer Government Oversight	- Market Entry Regulated for private ICFs by MHCC and by ADAA for public ICFs - Market Exit Through CON or Other Notice	Commission Decision (Certificate of Need/Notice) ADAA Decision (Contract, Memorandum of Understanding, Other Notice)
Option 4 Deregulation of ICFs from CON Review - Alcohol and Drug Abuse Administration (ADAA) /Drug and Alcohol Council(DAC)	Change and Shift Government Oversight	Limited Barriers to Market Entry or Exit	ADAA/DAC regulatory controls
Option 5 Deregulate ICFs from CON Review; Create Data Reporting Model	Reduce Government Oversight	No Barrier to Market Entry or Exit	Performance Reports/ Report Cards
Option 6 Deregulate ICF from CON Review	Eliminate Government Oversight	No Barrier to Market Entry or Exit	Remaining agencies exercise oversight authority (OHCQ, ADAA, Medicaid)

Source: Maryland Health Care Commission, August 2001

APPENDIX I

Appendix I
Maryland Inpatient Hospital and Emergency Room
Addiction Discharges and Visits
CY 1997 – CY 2000

	CY 1997			CY 1998			CY 1999			CY 2000		
	Inpatient	E.R.	Total	Inpatient	E.R.	Total	Inpatient	E.R.	Total	Inpatient	E.R.	Total
	Discharges	Visits		Discharges	Visits		Discharges	Visits		Discharges	Visits	
ANNE ARUNDEL MED. CTR.	162	446	608	152	575	727	134	593	727	131	557	688
ATLANTIC GENERAL HOSPITAL	23	85	108	26	145	171	13	131	144	23	154	177
BON SECOURS HOSPITAL	114	365	479	119	458	577	107	508	615	145	614	759
BOWIE HEALTHCARE CENTER	0	16	16	0	36	36	0	33	33	0	35	35
CALVERT MEMORIAL HOSPITAL	68	143	211	79	194	273	90	215	305	80	152	232
CARROLL CTY. GENERAL HOSPITAL	81	243	324	103	350	453	67	194	261	74	86	160
CHILDRENS HOSPITAL	1	0	1	7	0	7	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED
CHURCH HOSPITAL	57	383	440	100	578	678	42	378	420	CLOSED	CLOSED	CLOSED
CIVISTA MEDICAL CENTER	34	118	152	54	231	285	39	170	209	56	182	238
DOCTORS COMMUNITY HOSPITAL	61	72	133	69	105	174	36	110	146	65	81	146
DORCHESTER GENERAL HOSPITAL	38	55	93	86	75	161	79	140	219	124	103	227
FALLSTON HOSPITAL	0	164	164	0	214	214	0	217	217	0	0	0
FORT WASHINGTON MEDICAL CTR.	25	33	58	18	40	58	15	63	78	25	54	79
FRANKLIN SQUARE HOSPITAL	242	452	694	222	846	1,068	187	658	845	245	720	965
FREDERICK MEMORIAL HOSPITAL	100	473	573	107	509	616	173	566	739	241	557	798
GARRETT CTY. MEM. HOSPITAL	33	48	81	37	40	77	29	37	66	37	44	81
GOOD SAMARITAN HOSPITAL	78	126	204	113	228	341	117	281	398	95	301	396
GREATER BALTIMORE MED. CTR.	227	286	513	364	342	706	266	338	604	285	209	494
HARBOR HOSPITAL CENTER	88	357	445	112	524	636	98	486	584	127	530	657
HARFORD MEMORIAL HOSPITAL	169	173	342	153	238	391	156	311	467	130	324	454
HOLY CROSS HOSPITAL	112	246	358	106	312	418	101	298	399	112	269	381
HOWARD CTY. GENERAL HOSPITAL	169	263	432	119	341	460	131	331	462	127	319	446
J. HOPKINS BAYVIEW MED. CTR	2,207	722	2,929	2,276	1,212	3,488	2,433	705	3,138	2,692	26	2,718
JOHNS HOPKINS HOSPITAL	924	1,561	2,485	925	1,758	2,683	508	1,335	1,843	492	924	1,416
J.H. ONCOLOGY	10	0	10	5	0	5	3	0	3	5	0	5
KENT & QUEEN ANNE'S HOSPITAL	18	44	62	14	63	77	21	41	62	30	79	109
LAUREL REGIONAL HOSPITAL	157	281	438	144	388	532	138	155	293	154	190	344
LIBERTY MED. CENTER (CLOSED)	135	DNR	135	136	DNR	136	52	DNR	52	CLOSED	CLOSED	0
MARYLAND GENERAL HOSPITAL	348	476	824	423	805	1,228	375	1,000	1,375	390	1,004	1,394
MCCREADY MEMORIAL HOSPITAL	12	10	22	12	21	33	7	24	31	5	11	16
MEM. HOSP. AT EASTON	108	95	203	127	216	343	99	179	278	118	153	271
MEMORIAL OF CUMBERLAND HOSP.	41	26	67	50	82	132	52	65	117	48	59	107
MERCY MEDICAL CENTER	951	471	1,422	984	560	1,544	971	697	1,668	1,127	851	1,978
MONTGOMERY GENERAL HOSPITAL	331	277	608	342	439	781	329	301	630	416	269	685
NORTH ARUNDEL HOSPITAL	159	462	621	190	673	863	170	516	686	208	714	922
NORTHWEST HOSPITAL CENTER	87	299	386	79	422	501	91	378	469	77	395	472
PENINSULA REGIONAL MED CTR	152	246	398	148	418	566	120	398	518	146	421	567

PRINCE GEORGES HOSP. CTR.	195	425	620	199	427	626	204	307	511	167	197	364
SACRED HEART HOSPITAL	163	6	169	117	61	178	88	177	265	96	167	263
SAINT JOSEPH HOSPITAL	93	197	290	100	223	323	78	178	256	96	232	328
SHADY GROVE HOSPITAL	124	288	412	84	354	438	98	348	446	90	359	449
SINAI HOSPITAL	285	281	566	156	753	909	145	798	943	155	819	974
SOUTHERN MARYLAND HOSPITAL	98	108	206	113	158	271	95	205	300	115	24	139
ST. AGNES HEALTHCARE	184	132	316	191	481	672	171	643	814	184	696	880
ST. MARY'S HOSPITAL	58	147	205	54	201	255	43	61	104	64	47	111
SUBURBAN HOSPITAL	404	218	622	481	275	756	410	217	627	406	273	679
U OF MD HOSPITAL	410	272	682	510	646	1,156	358	641	999	400	716	1,116
UNION MEMORIAL HOSPITAL	176	519	695	195	750	945	142	681	823	173	615	788
UNION OF CECIL HOSPITAL	145	129	274	136	191	327	135	68	203	120	287	407
UPPER CHESAPEAKE MED. CTR.	58	0	58	65	0	65	80	0	80	86	172	258
WASH. ADVENTIST HOSPITAL	214	389	603	159	537	696	147	574	721	132	556	688
WASHINGTON CTY. HOSPITAL	296	265	561	319	447	766	345	472	817	352	464	816
ALL HOSPITALS	10,425	12,893	23,318	10,880	18,942	29,822	9,335	17,222	26,557	10,666	16,011	26,677

Note: Inpatient discharges who are admitted from the emergency room are not counted in the emergency room count and therefore are not duplicative. This data is not included i any SAMIS, ADAA reports.

DNR: Did Not Report

Source: Maryland Health Care Commission, Maryland Hospital Discharge and Emergency Room Abstract, CY 1997-CY 2000